



# EMSC CONNECTION Newsletter

MONTANA EMERGENCY MEDICAL SERVICES FOR CHILDREN



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EMS & Trauma Section  
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## A word from the EMSC Program Manager:

### Greetings!

The Emergency Medical Services for Children (EMSC) Program aims to ensure that emergency medical care for the ill and injured child or adolescent is well integrated into an emergency medical service system.



We work to ensure that the system is backed by optimal resources and that the entire spectrum of emergency services (*prevention, emergency response, prehospital care, hospital care, interfacility transport, and rehabilitation*) is provided to children and adolescents, no matter where they live, attend school or travel.

**THE RIGHT CARE AT THE RIGHT PLACE AT  
THE RIGHT TIME  
WITH THE RIGHT RESOURCES!**

Exciting news and events are

going

on this month.

**See What's New!**



### WHAT'S NEW?

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## FAMILY CENTERED CARE

At the heart of patient family-centered care is the belief that health care staff and the family are partners, working together to best meet the needs of the child. Excellence in health care happens when we work together and honor the expertise each of us brings to every health encounter. Patient family centered care is a continual effort to be responsive to the needs and choices of each family.



### The core concepts of Patient Family Centered Care are:

- **Dignity and Respect**-To Listen to and honor patient and family ideas and choices and to use patient and family knowledge, values, beliefs and cultural backgrounds to improve care planning and delivery.
- **Information Sharing**-To communicate and share complete and unbiased information with patients and families in useful ways. Patients and families receive timely, complete and accurate details so they can take part in care and decision making.
- **Involvement**-To encourage and support patients and families in care and decision making at the level they choose.
- **Collaboration**-To invite patients and family members to work together with health care staff to develop and evaluate policies and programs.

### The core concepts of Patient Family Centered Care place value on:

- Recognizing that each child and each family is unique. Families have different personalities, life experiences, values, beliefs, education, and religious and cultural backgrounds. Care provided should be equal to all patients and flexible so that the needs and choices of families can be met.
- Open honest communication between patients, their families, and health care staff. Being willing to talk about the bad as well as the good is important for changing, improving, and developing best care practices and policies. This kind of clear communication enhances the patient's and family's health care experience.
- Empowering of families to join in their child's health care journey. When families and patients understand their options, they are empowered to be involved in their child's care.
- Acknowledging that families are allies for quality and safety within the health care system. By working together, families and staff are strengthened by their partnership and shared knowledge.

## DID YOU KNOW IN MONTANA?

**Montana ranks 33<sup>rd</sup>**  
**among all states for**  
**child well-being**

7.4% Babies have low birth weight {U.S. Average 8.2%}

73% are born to mothers who receive early prenatal care {National Healthy People goal is 90%}

64% of two-year-olds are immunized {U.S. average 75%}    35% of births are covered by Medicaid

59% of children on public insurance have a medical home

51 % of Montana infants and toddlers live in low-income families {U.S. is 46%}

11.5% infants are born preterm, earning Montana a grade D compared to national objective

# TEN COMPONENTS OF FAMILY-CENTERED CARE



Family-centered care accomplishes the following:

1. Acknowledges the family as the constant in a child's life.
2. Builds on family strengths.
3. Supports the child in learning about and participating in his/her care and decision-making.
4. Honors cultural diversity and family traditions.
5. Recognizes the importance of community-based services.
6. Promotes an individual and developmental approach.
7. Encourages family-to-family and peer support.
8. Supports youth as they transition to adulthood.
9. Develops policies, practices, and systems that are family-friendly and family-centered in all settings.
10. Celebrates successes.

(National Center for Family-Centered Care (1989); Bishop, Woll and Arango (1993))



## STRATEGIES FOR LEADERSHIP: PATIENT AND FAMILY CENTERED CARE.

To help hospitals become more patient and family-focused in their care practices, the AHA partnered with the Institute for Family-Centered Care, a non-profit organization that serves as a resource for consumers, practitioners and policymakers who want to advance the practice of family-centered care, to produce the toolkit *Strategies for Leadership: Patient- and Family Centered Care*.

**[Download the Video](#)** (72 MB, Run Time: 13:50, WMV - Windows Media format) *Patient- and Family-Centered Care: Partnerships for Quality and Safety* describes the core concepts of patient- and family-centered care and features compelling stories from patients, families, caregivers and hospital leaders. Note: On most high-speed connections, this will take a few minutes to download. You will need **[Windows Media Player](#)** to play this video.

**[Video Discussion Guide](#)** – to help hospital leaders discuss this issue in leadership forums and develop an action plan.

**[Resource Guide](#)** – provides more information about the concepts of patient- and family-centered care as well as guidance on how to advance such care within organizations. Case studies and a listing of additional resources and references also are featured.

**[Hospital Self-Assessment Tool](#)** – to be used by either hospitals' leadership team or an organizational cross-functional team (which includes patients),

<http://www.aha.org/advocacy-issues/quality/strategies-patientcentered.shtml>

## EMSC Family Representative

Family Representatives for EMSC are individuals selected to represent the needs of families in the community or State. Family Representatives offer leadership to effect system change, and assure that family issues are not overlooked and are leaders in the community. One of the Montana EMSC Family Representatives is Robyn VanHemelryck. Here is a message from Robyn.....



### Robyn VanHemelryck: What Family Centered Care Means to the Families

Family Centered Care is a systematic approach to building collaborative relationships between health care professionals and families. Relationships are built through communication and involvement of the families. This collaboration empowers families and leads to the best possible outcomes for children. Family Centered Care helps families establish and retain a sense of control while improving patient safety, quality of care and satisfaction.

I am a Mother of three beautiful children ages 11, 14 and 18. We have used several departments within our healthcare system. My oldest daughter was a gymnast and has sustained several injuries throughout her career. My youngest son has asthma and my middle daughter has a heart condition that has required her to have five open heart surgeries. She also sustained a broken arm and pelvis while playing on playground equipment at her elementary school. As parents, my husband and I have been involved in facilities that implement Family Centered Care as well as those who are not as familiar or hesitant to use this approach.

Our most positive experience was in the hospital where she had her heart surgeries. Her heart defect was found at birth so she has been in and out of hospitals and doctor's offices her entire life. Like most kids, she is afraid to have her blood drawn and is afraid of any kind of needle that comes within sight. She gets extremely anxious any time she has to go anywhere near a doctor's office or hospital.

The hospital did an amazing job of including my husband and me as well as our daughter from the moment we walked through their doors. They talked to us and we were able to make them aware of her fear and anxiety. We were able to be by her side through every test, every procedure and every doctor's visit. They talked in terms that not only we could understand but that she could understand. They used their Child Life Specialist to help her understand what was going to happen in every step of the way. We were able to stay with her before her surgeries until the last possible moments when she disappeared behind those double doors. After her surgeries, they allowed us to stay in the room with her during her stay in the ICU and then down to her regular room. We were never kicked out when the doctor's came in. We were always engaged in their conversations. We shared ideas on how to make her more comfortable and brainstormed ways to help her with her anxiety.

We also assisted in various medical procedures which helped with her anxiety level. I distinctly remember a very scary moment in the ICU after her second surgery where she was losing a lot of blood and everything seemed to be going downhill very quickly. They never kicked us out of her room. One doctor sat and explained everything that they were doing at that moment and what they would be doing as they took her back to the OR. Although it was a terrifying moment, we felt much more at ease as they took her back because we knew exactly what was happening and what would happen once they were behind those closed doors.

The staff was always amazed on how quickly she recovered every time she was in the hospital. We truly believe that it was because we were so involved every step of the way which helped her in the recovery process. **When Family Centered Care is implemented it increases the quality of patient care, patient satisfaction and achieves the best possible outcome for our children.**



## COMMON REASONS FOR ED VISITS

- In 2009–2010, cold symptoms were the most common reason for emergency room visits by children (27 percent), and injuries were the most common reason for visits by adults (14 percent.)



### HIGHLIGHTS

- In 2010, there were over 25.5 million emergency department (ED) visits for children younger than 18 years; the vast majority (96 percent) of those visits resulted in children being treated and released.
- Boys accounted for a slightly larger proportion of pediatric ED visits, regardless of whether the visits resulted in the child being treated and released or being hospitalized.
- The proportion of ED visits was inversely related to wealth: ED visits for children from the poorest communities accounted for about twice as many visits as children from the wealthiest communities.
- Medicaid was the largest primary expected payer for ED visits for the youngest pediatric age groups.
- Injuries and poisoning and respiratory disorders were the most common reasons for ED visits for older and younger children, respectively.
- Mood disorders and attention-deficit, conduct, and disruptive behavioral disorders were common reasons for ED visits that resulted in admission among older children.

### REASON FOR ED VISIT UNDER 18 YEARS OF AGE



Cold symptoms . . . . .	26.8%	Injury . . . . .	21.0%
Nausea or vomiting. . . . .	5.2%	Skin symptoms . . . . .	4.5%
Abdominal pain . . . . .	4.3%	Breathing problems. . . . .	3.5%
Leg problems . . . . .	3.5 %	Arm problems . . . . .	3.4%
Earache . . . . .	3.3 %	Headache. . . . .	2.2%
Falls. . . . .	9.6%	Struck by/against objects....	5.6%
Motor vehicle traffic . . . . .	2.0%	Cut or pierce . . . . .	1.7%
Environmental, exposure.....	2.0%	Poisoning . . . . .	0.9%
Overexertion . . . . .	1.0%		

<http://www.cdc.gov/nchs/data/hus/>

### **DID YOU KNOW?** 14 % of Montana's youngest children don't have health insurance

Uninsured children are 3 times less likely to have seen a doctor compared to insured children, and the need for health care during a child's earliest years is more crucial than at most other times in life, as preventative care and screening can catch problems early.

## FAMILIES

### **Families with Children or Adults with Disabilities**

Emergency preparedness is especially important when a family member has a disability. The federal government's emergency preparedness website, [www.ready.gov](http://www.ready.gov), has a brochure with tips for these families, "Prepare for Emergencies Now: Information for People with Disabilities." Many of the tips are relevant to all families.

**Be Informed:** For more information about specific types of emergencies that may affect your area, visit [www.ready.gov/be-informed](http://www.ready.gov/be-informed)"

**Make a Communications Plan:** In an emergency, families' support network (family, friends, etc.) need to know where they will be located in shelter or after an evacuation.

**Build an Emergency Kit:** What supplies would families need if access to grocery stores or pharmacies was cut off for days?

**Get Involved:** Consider helping your community become more prepared for emergencies, especially considering the needs of those with disabilities. To read more about these tips, you can download the brochure at: [www.ready.gov/sites/default/files/FEMA\\_Disabilities\\_R-6\\_web\\_june2012.pdf](http://www.ready.gov/sites/default/files/FEMA_Disabilities_R-6_web_june2012.pdf)

### **Tribal Materials**

Ready.gov also has materials written especially for tribal leaders, as well as regionally specific information. See: [http://www.ready.gov/sites/default/file/Brochure\\_Leaders.pdf](http://www.ready.gov/sites/default/file/Brochure_Leaders.pdf)

### **Kids Need to Prepare, Too!**

Here's a coloring/activity book to help children be prepared:

[www.ready.gov/sites/default/files/documents/files/ReadyKids-ActivityBook.pdf](http://www.ready.gov/sites/default/files/documents/files/ReadyKids-ActivityBook.pdf)



### **Family-to-Family Health Information Centers are Ready to Help!**

Each state and the District of Columbia have these "F2F HICs" to help families with children and youth with special health care needs. They can provide assistance and support in emergency preparation as well. To learn more about the F2F HICs, or to find one in your state, go to:

[www.familyvoices.org/states](http://www.familyvoices.org/states)

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## **ICD-10 Deadline is October 1, 2014**

The compliance deadline for ICD-10 is October 1, 2014. CMS Administrator Marilyn Tavenner has affirmed the ICD-10 deadline and encourages providers, payers, and vendors across the health care industry to prepare to use the new codes for services provided on or after October 1, 2014. The [CMS website](http://www.cms.gov) offers a variety of resources targeted to [Providers](#), and others to help you with your transition to ICD-10. Timelines, checklists, fact sheets, and in-depth guides are all available to help you and your organization plan for a smooth transition. Keep Up to Date on ICD-10 Visit the CMS [ICD-10 website](#) for the latest news and resources,

## Bright Futures?



**Bright Futures** is a national health promotion and disease prevention initiative that addresses children's health needs in the context of family and community. In addition, the goal of the Bright Futures project is to respond to the emerging preventive and health promotion needs of infants, children, and adolescents. The Maternal and Child Health Bureau of the U.S. Public Health Service and the Medicaid Bureau of the Health Care Financing Administration sponsor Bright Futures.

Over 100 professionals, representing a spectrum of child health perspectives, developed health supervision guidelines to advance health needs of children.

The **Bright Futures Guidelines** arise from the belief that effective health supervision requires a partnership between health professionals and families. The health professional must use a "contextual approach," becoming sensitive to the child's environment, including health, educational, and social issues.

This guide is divided into four sections that correspond to the four periods of development of infancy (0-12 months), early childhood (1-5 years), middle childhood (5-11 years), and adolescence (11-21 years).

Each section includes: (1) a theme chapter; (2) a chart of developmental achievements, tasks, and outcomes; (3) a list of instructions concerning health supervision to be provided to the family by health professionals; (4) a list of child, family, and community strengths; (5) a list of health-related issues; (6) descriptions of what typically occurs at periodic visits of children and families to health professionals; (7) a health supervision summary; and (8) a bibliography.

These are of key importance to families and health care professionals in their common mission to promote the health and well-being of children from birth through adolescence.

As a result, the **Bright Futures Guidelines** developers decided to create a new Health Promotion Themes section. These **Health Promotion Themes** are designed for the health care professional who desires an in-depth, state-of-the-art discussion of a certain child health topic with evidence regarding effectiveness of health promotion interventions at specific developmental stages from birth to early adulthood. These comprehensive discussions also can help families understand the context of their child's health and support their child's and family's health.

The Health Promotion Themes are:

Promoting Family Support;      Promoting Child Development;      Promoting Mental Health;  
Promoting Healthy Weight;      Promoting Healthy Nutrition;      Promoting Physical Activity;  
Promoting Oral Health;      Promoting Healthy Sexual Development and Sexuality;  
Promoting Safety and Injury Prevention; and  
Promoting Community Relationships and Resources.

[http://www.eric.ed.gov/ERICWebPortal/search/detailmini.jsp?\\_nfpb=true&\\_ERICExtSearch\\_SearchValue\\_0=ED386312&ERICExtSearch\\_SearchType\\_0=no&accno=ED386312http://brightfutures.aap.org/index.html](http://www.eric.ed.gov/ERICWebPortal/search/detailmini.jsp?_nfpb=true&_ERICExtSearch_SearchValue_0=ED386312&ERICExtSearch_SearchType_0=no&accno=ED386312http://brightfutures.aap.org/index.html)

## TRIVIA CONTEST:

First 3 to answer the questions wins a free PEDIATRIC ASSESSMENT POSTER and a sweet gift!  
Email [rsuzor@mt.gov](mailto:rsuzor@mt.gov))

Which finger has the fastest growing nail?

Which human bone is most often broken?

When the sun activates your melanocytes what appear on your body?

What non-contagious disease is the most common?



**REMEMBER THE 2013 MONTANA TRAUMA SYSTEMS CONFERENCE SEPTEMBER 11, 2013 AND THE ROCKY MOUNTAIN RURAL TRAUMA SYMPOSIUM SEPTEMBER 12-13, 2013 AT THE BEST WESTERN HERITAGE INN, GREAT FALLS. Register at <http://www.45pr.com/Register%20for%202013%20Symposium.html>**

## TRAINING AVAILABLE



### EMS ONLINE.NET

EMS Online began as an online continuing education program for EMT's in King County. The program now serves Paramedics, EMT's and Dispatchers in Washington, and has expanded to serve federal, state, local, private and international agencies. EMS Online focuses on providing high quality content, reviewed by experts in the field, allowing training officers and instructors to focus on practical skills training and assessment. The courses meet and exceed National Standards and are National Registry approved with state authorization. Each course consists of two components; the online didactic portion provided by EMS Online as well as the practical skills assessment that is completed at the agency. For additional information, please contact Michelle Lightfoot at 206-263-8585 or [subscribe@emsonline.net](mailto:subscribe@emsonline.net).

### MUTUAL AID FOR EMS

In collaboration with the MT Hospital Preparedness Program, the opportunity is available to get CEUs and to upgrade communications capability at the same time. To qualify for the FREE digital radio 50% of the members of the EMS agency must complete the *MUTUAL AID for EMS* on the EMS&T's LearningZen software. The radio is a Motorola XT2500 mobile radio with rear control and encryption. Go to <https://mtemergencycare.learningzen.com>.

### PREHOSPITAL TRAUMA LIFE SUPPORT COURSE (PHTLS),

World's premier prehospital trauma education developed in cooperation with the American College of Surgeons to promote critical thinking in addressing multi-system trauma and provide the latest evidence-based treatment practices. PHTLS is designed for both BLS and ALS providers. For further information contact Shari Graham, EMS System Manager at 406-444-6098 or [sgraham2@mt.gov](mailto:sgraham2@mt.gov).



## CHILDREN'S HEALTH AND WELLNESS GRANTS AVAILABLE

This year the Build-A-Bear Workshop foundations is accepting and reviewing grant applications on a rolling basis until October 31st for the following categories:

- Children's Health and Wellness: grants for nonprofit organizations such as childhood disease research foundations, child safety organizations, and organizations that serve children with special needs;
- Literacy and Education: grants for nonprofit literacy and education programs such as summer reading programs, early childhood education programs and literacy programs for children with special needs. Miscellaneous grant requests will also be considered by the foundation from organizations working to support children, families, and the environment through programs not easily categorized.
- Grants are made as one-time contributions and range from \$1,000 to \$5,000. Deadline: October 31, 2013.



[Click here for the link to the online application.](#)

[Click here for specific guidelines for children's health and wellness grants.](#)



### A Comprehensive View of Parental Satisfaction with Pediatric Emergency Department Visits

The *Annals of Emergency Medicine* published a [study](#) to develop a comprehensive view of aspects of care associated with parental satisfaction with pediatric emergency departments (ED) visits, using both quantitative and qualitative data. 2,442 parents who brought their child to the ED were interviewed with telephone survey methods.

Overall, parental satisfaction was best predicted by how well physicians and nurses work together, followed by wait time and pain management. Issues concerning timeliness of care, perceived quality of medical care, and communication were raised repeatedly by parents in response to open-ended interview questions.

A cognitive interview-style question showed that physicians and nurses sharing information with each other, parents receiving consistent and detailed explanation of their child's diagnosis and treatments, and not having to answer the same question repeatedly informed parent perceptions of physicians and nurses working well together. The study concludes, using qualitative data to augment and clarify quantitative data from patient experience of care surveys is essential to obtaining a complete picture of aspects of emergency care important to parents and can help inform quality improvement work aimed at improving satisfaction with care.

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